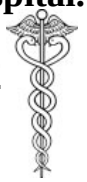
CHAPTER 5

MEDICAL ISSUES

Victims of domestic violence and sexual assault may need medical treatment to recover from their abuse. Not only are survivors emotionally affected by their abuse, they may also be physically injured. As a counselor/advocate, it is important for you to recommend medical attention and explain to her what is expected when at the hospital.

DOMESTIC VIOLENCE
Medical concerns



For a victim of domestic violence, medical treatment is an important part of the emotional healing process as well as the physical. As a hotline crisis intervention counselor, it is necessary for you to encourage a woman who has suffered recent physical abuse to seriously consider the option of seeking medical attention promptly. The underlying message to the woman calling is that she is valuable in herself because she is a valuable human being, her health and welfare is important.

Many victims of abuse do not show physical signs of abuse. In many instances, the abuser will hit, punch, or kick in places where bruises will show (i.e. head, buttocks, back, stomach, and breasts). A woman who has been beaten in any of these areas may have sustained internal injuries.

Another common form of abuse is strangulation, as well as suffocation, which may not produce bruises, but can lead to serious medical problems because the victim is deprived of oxygen during the attack.

It is important for victims to understand that: first, the examination is for her own well being; second, that the exam provides documentation of the attack.

If a woman has been beaten, even if there are no visible signs, talk to her about the option of seeking medical treatment. Even if the woman does not want to press charges, she should be encouraged to go to a hospital emergency room or her family physician for treatment and documentation. The next beating she endures may be the one that spurs her into action. Past documentation will help her prove her case if she chooses legal remedy to the abusive situation.

As a hotline crises counselor, you can reassure the victim that even though she is seeking medical treatment, she will not have to press charges unless she

chooses that option. In Pennsylvania, there is no mandated reporting of domestic violence, which means hospital personnel will not have to report the incident to the police unless the victim chooses to. The exception to this is: if the incident of abuse involved a gun, knife, firearm or other deadly weapon, then the medical personnel must call the police.

When the domestic violence victim decides to seek medical attention, TWC may provide an advocate to accompany the woman to the hospital or to her physician's office. The woman should be informed of that option. She does not have to go alone. If the woman requests an advocate, transportation will have to be discussed. An advocate can meet her at the hospital or physicians office at the agreed upon time.

If the victim requests more information about what to expect when at the hospital, the following procedure may be discussed with her:

The victim will tell the physician or nurse exactly what happened and other pertinent details:

1. When the assault occurred.
2. Relationship to assailant.
3. What type of abuse occurred (hitting, punching, kicking, strangling, etc.)
4. Where she was hurt (head, back, stomach, breast, etc.).
5. If she was unconscious for any period of time.
6. If she is pregnant.
7. If there was a weapon involved.
8. Drug or alcohol involvement.

The physician and/or nurse will document:

- Her general appearance and emotional state.
- The physician should make a thorough examination to check for possible cuts or bruises of which she may not be aware.
- If bruises are visible, the hospital personnel may take color pictures of bruises, cuts, torn clothes, etc.
- Torn and/or bloody clothing should be saved and not washed.
- Subsequent visits to the hospital or family physician should be documented to show severity of abuse.
- Consent, written and witnessed, for the following should be obtained at the hospital:
  - Treatment.
  - Photographs (if taken by hospital personnel).
  - Release of information to proper authorities. Hospitals do not contact

the police department unless the victim requests that the police are notified. (Hospitals/physicians in Pennsylvania are required to report, however, all wounds inflicted by firearms.)
Remember; her medical records and her conversation with her doctor are confidential until she decides otherwise. She must give consent to release information to proper authorities before medical information is released, except in the case of abuse involving a weapon.

Physicians Initial Assessment: Questions That May Be Asked of the Battered Woman

- ✓ Where is the batterer now?
- ✓ Where are the children? Are they safe?
- ✓ How long ago did the abuse take place?
- ✓ Is this the first incident of abuse?
- ✓ Who brought her to the hospital?
- ✓ Is there some place, other than home, where she can go to recuperate if it is too dangerous for her to return home?
- ✓ Were there weapons involved in the battering incident?
- ✓ Would she like to speak with an Advocate from The Women's Center?
- ✓ Would she like to call the police if they haven't been notified already?

PROVIDING HEALTH CARE IN SHELTER

Women and children in shelters experience the health problems of women and children everywhere, plus additional problems endemic to group living and battering relationships. When women and their children are first admitted to shelters, there is a need to assess them for injury from beating, check for communicable diseases and make sure that ongoing health problems can be properly dealt with in the shelter. During the stay at the shelter, outbreaks of communicable diseases can occur and various injuries can happen, especially among the children. The shelter stay can also be an opportunity to promote health; address ongoing health concerns, and establishes a better plan for obtaining health care after the shelter residency.

INJURIES FROM BATTERING

As shelters have found through experience, it is best to be safe and refer any woman at all seriously injured from a beating to an emergency room or clinic for examination. Serious internal or head injuries can appear relatively innocuous. Thus, any woman coming for intake who has visible signs of beating on the head, who complains of having been kicked or punched in the ribs or stomach, or who lost consciousness even momentarily during the beating, should be examined by a health professional. Even if the woman has been to an emergency room before shelter admission, these kinds of injuries may have been overlooked, especially if she was bleeding profusely or had a visible facial injury. One way to protect against this possibility is to make sure that she had a complete physical at the emergency room.

Another helpful possibility is to have a network of nurses "on call" who can be contacted by telephone for assistance if the intake worker is unsure of the best direction to take.

Particular Health Prob1ems of Battered Women

It has been documented that battered women experience more physical symptoms than other groups of women. These have sometimes been characterized as "psychosomatic symptoms," implying that they are a sign of emotional problems. However, such physical symptoms can be the result of old and new injuries from battering. They are also frequently physical manifestations of stress, the stress of battering and/or the stress of leaving a spouse and most of one's belongings to come to an unknown place. In addition, there may be other health problems that are causing the symptoms. A thorough health assessment may be extremely important in sorting out what is happening to the battered woman. She may have neglected her own health because she was too embarrassed to seek out the health care system or was prevented from doing so by her spouse.

Battering during pregnancy is also a frequent occurrence. The pregnant woman in the shelter is at risk for pregnancy complications, including premature labor and miscarriage, resulting from the battering. She will also commonly experience a strong desire to reconcile with her spouse so that the baby will know its father. It is useful to have an organization providing prenatal classes connected with the shelter so those women can attend classes while in residence even if it is only on a one-time basis. Nurses can also provide individual information and instruction.

Finally, sexual abuse has been documented as occurring in approximately 40 percent of all cases of battering. This is a subject which battered women are not likely to bring up unless asked about it directly. Yet it is an issue with serious emotional and health implications of its own. If nurses are providing regular health assessments at the shelter, sexual abuse should be part of the history. The question, "Has your partner ever forced you into sex you did not wish to participate in?" has been used successfully to elicit the information. If the woman replies affirmatively, she can be asked to describe what happened.

The advantage of having a nurse inquire into this area is that the nurse can then perform a physical examination to determine if there has been vaginal or anal trauma. In addition, a nurse can talk to the woman in depth about sex-related fears and any secondary physical symptoms as a result of the sexual abuse. If nursing care is not available at the shelter, shelter workers can fulfill at least the verbal parts of this process.

--By Jacquelyn Campbell and Janice Humphreys, Wisconsin Coalition Against Domestic Violence, 3/88

Domestic Violence and Pregnancy

Definition: ***The American College of Obstetricians and Gynecologists define domestic violence as a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, used against current or former intimate partners***.

Statistics

- Pregnancy itself is a risk factor for battering
- 15% to 25% of pregnant women and teens are battered
- One in four pregnant women have a history of domestic violence
- Women who have experienced physical assault before pregnancy are at a greater risk for battering during pregnancy
- A battered pregnant woman is four times more likely to have a low birth weight baby and her chances of miscarriage double

Effects of Domestic Violence on Pregnant Women

- Battered women are more likely to develop pregnancy problems from the abuse than from any other complication
- Domestic violence is associated with unintended pregnancies and may be related to inconsistent contraceptive use
- Women who had mistimed or unwanted pregnancies reported significantly higher levels of abuse during the 12 months before conception or during pregnancy (12.6% and 15.3%, respectively) compared with those with intended pregnancies (5.3%)
- Abused women are twice as likely as non-abused women to delay prenatal care until the 3rd trimester, and often they only keep appointments sporadically
- Domestic violence can cause:

Spontaneous miscarriage
Low weight gain
Poor nutrition
Pre-term labor
Anemia
Infections
Depression
Suicide attempts
First & Second trimester bleeding
Tobacco, alcohol & illicit drug use

Effects of Domestic Violence on the Neonate

- Domestic violence can cause the following infant complications:
  - Low birth weight
  - Feeding problems
  - Irritability
  - Growth delays
  - Failure to thrive
  - Inappropriate bonding
  - Sleep disturbances
  - Illness
  - Fetal Injuries, such as fetal fracture
  - Shaken baby syndrome (head trauma/brain damage)
  - Death

Differences in Domestic Violence during Pregnancy

- Abuse may increase during pregnancy
  - Abuse may begin during pregnancy
  - Or abuse may increase for women previously abused
- Abused women may experience a respite time
  - Some women are not battered during pregnancy and may become pregnant to experience this respite time
- Abuse may increase during the postpartum period
  - If pregnancy was respite time, the abuse will resume during postpartum period and may increase to "make up for lost time"
  - Abuse may also begin or increase during postpartum period due to jealously over the attention the baby gets or the bond the mother and babies have

Why Pregnant Battered Women Stay

- May dread being alone during labor
- May need help from partner after baby is born
- Cannot financially support the baby or medical costs
- Hope the abuse will stop (IT WILL NOT)
- May not want to raise the child alone
- Lack of support system

Signs of Abuse from Pregnant Women

- Evasive in conversation
- Talks of being under a lot of stress
- Voices vague physical complaints not typical of pregnancy
- Delay of prenatal care
- Frequent calls to health care provider for seemingly inappropriate reasons

SEXUAL ASSAULT

Most hospitals have a specific set of procedures regarding sexual assault, known as the rape protocol, which includes notification of police that a sexual assault has occurred, and conducting with the victim's permission, what is known as the rape exam.

The rape exam is important for medical and for legal reasons. The following is a description of the physical effects of sexual assault.

MEDICAL CONCERNS

Injury to the Genital Area

Injury to the genital area may include bruising and/or lacerations to the perineum, hymen, vulva, vagina, cervix, and/or anus. In addition, there may be bleeding and injury to deeper pelvic tissue. Although physical injuries heal, the sexual assault can lead to the victim having what might appear to be physical problems.

Problems such as dyspareunia (painful intercourse), vaginismus (spasms of the vaginal muscles) and inability to achieve orgasm during voluntary sexual encounters may be long-term effects after a sexual assault.

Injury to the Body

Depending upon the nature of the rape, other areas of the body, besides the genitals may be bruised, bleeding, and or severely damaged or injured. It is the responsibility of the advocate to recommend immediate medical attention to the survivor.

Sexually Transmitted Diseases

Sexually transmitted diseases are an important concern for all victims of sexual assault. As an advocate, you should be able to discuss this issue with victims, but advocates are not trained medical professionals, so the discussion of specific information regarding the diseases, symptoms, and possible treatment should be reserved for the physician and/or nurse. It is important to know that women may contract and incubate some diseases and show no visible symptoms. Victims should be cautioned to be alert to any symptoms out of the ordinary and to follow up the rape exam with visits to her personal physician, a Family Planning Agency or the PA Department of Health.

It is strongly recommended that sexual assault survivors retest 4-6 weeks after the assault. These early tests taken at the time of the rape may only show if the victim had any sexually transmitted disease prior to the assault.

AIDS/HIV and the Sexual Assault Victim

Given the current information, it is believed that the contraction of HIV virus during a single act of sexual assault is unlikely; a sexual assault does not significantly increase the victim's risk of infection. If she was a low risk prior to the assault, she remains at low risk after the incident; similarly with those at high risk.

WE DO NOT RECOMMEND TESTING VICTIMS IN THE ER for the following reasons:

- *It is next to impossible to prove that a victim became infected as a result of a sexual assault. Testing at this time will only indicate the victim's HIV status prior to the assault. Even if the victim tests negative now and positive six months later, she could have been exposed to HIV long before the assault, but only recently seronconverted.*
- *Confidentiality cannot be guaranteed in emergency room testing for HIV.*
- *If tested, the victim is at risk for discrimination, especially regarding insurance matters.*
- *HIV testing in the ER is expensive: if the victim tries to have her insurance company pay for it, the company would have access to the information on her HIV status, as would her employer if her insurance is paid through work.*
- *The victim would have to be retested at intervals regardless of the status of the baseline test. The HIV status of the perpetrator would have to be known also; and the proof that there was no other source of infection for up to 13 months prior to the assault.*
- *The time of the rape exam is not an appropriate time for pre-test counseling for HIV testing. The victim is already in crisis.*
- *For the victim's own peace of mind, she may later want to be tested at the Pennsylvania Department of Health centers are recommended where tests for HIV are free and confidential, and pre- and post-test counseling is available.*

Pregnancy and Pregnancy Options

For many rape victims, the fear of pregnancy is one of the most prevalent concerns. It is important for an advocate to acknowledge this concern and let her know there are options available, in case pregnancy should result from the attack. Advocates should be aware of the option of Emergency Contraception that can be obtained at the Emergency Department if a rape kit is performed. However, it is not the role of the advocate to go into great detail in the discussion of pregnancy options. Instead, an appropriate referral should be made to the physician, a Family Planning Agency, or a hospital OB/GYN department. The advocate should provide support for the victim, whatever her choice of options might be. The advocate should never allow his or her own biases to show through during the discussion of pregnancy. It is always the victim's right to choose which option is most appropriate for her.

EVIDENCE COLLECTION

In addition to medical reasons, the rape exam provides police/crime lab/ prosecutor with evidence about the rape in case the survivor decides to press criminal charges. For forensic purposes, the rape exam should be conducted as soon as possible after the rape (within 24-72 hours). A physical examination should be encouraged and conducted in all cases regardless of the length of time that may have elapsed between the time of the rape and the exam. In some cases, evidence may still be gathered after a 48 - hour period to document findings such as bruises, lacerations, or bite marks that may be present.

The consent of the survivor is fundamental to conducting the examination as well as to the collection and release of evidence. Informed consents should be an ongoing process that involves more than the survivor's signature on hospital consent forms. All procedures should be explained step by step so she knows what to expect and why something is done. This is where the medical advocate can be especially critical. If the victim consents to have the medical advocate present during the exam, the advocate can take the time to explain each step and support the victim through the procedure. The survivor has the right to make her own decisions about testing and evidence gathering procedures. This is especially important and necessary for her to regain a sense of control in the beginning stages of examination and interviewing. ***Having a sense of control is an important part of the healing process for sexual assault survivors***.

Maintaining the chain of custody during the exam is a ***function of*** and the ***responsibility of*** the attending medical personnel and law enforcement officers. At

no time should the medical advocate touch any medications, specimens, or other evidence during or after collection. These must always be in the possession of the medical personnel or law enforcement officer; otherwise the chain of custody of evidence would be broken. *At no time should a police officer, male or female, be present during a medical exam. There is no medical or legal reason for their presence in the examination room.*

General Overview of the Rape Examination and Evidence Collection

Identification/Consent

I. Labels completed by medical personnel with date, victim's name, and medical Personnel's name.
2. Victim's consent should be signed by her and witnessed before exam.

Interview the Survivor (by Medical Personnel)

I. Medical history - cardiac history, allergies, current medications
2. History of STD'S, hepatitis
3. Clothing worn during the sexual assault
4. Description of clothing
5. Sexual history - OB history, last voluntary sexual intercourse, method of contraception used, any contraception used during assault?
6. Has victim bathed, douched, showered, and had anything to eat, drink since assault.

History of Assault

1. Date, time, location
2. Number of assailants, race of assailant(s) are they known to the victim?
3. Threats - Use direct quotes if possible
4. Restraints - Describe
5. Weapons used - Describe
6. Describe the sexual assault. Record specific sexual acts.

Physical Exam & ***Collection of Evidence***

1**.** Preserve clothing. Ensure clothing is placed in a ***paper bag***, not plastic, labeled and initiated by medical examiner.
2. Describe trauma - diagram if possible.
3. Check entire body for sign of injury/trauma.
4. Medical Examiner will obtain: head hairs, pubic hairs, oral swabs, vaginal/anal

swabs, cultures, saliva samples, Blood samples, fingernail scrapings and pelvic examination.
5. Hospital/Police or Medial Advocate will take photographs, if needed.
6. Evidence sealed, labeled, initiated by examiner.
7. Examiner counts evidence, finishes chart, and gives law enforcement evidence kit.
8. Both sign kit together, record date and time.
9. Law Enforcement transports evidence to appropriate lab.

THE ROLE OF THE ADVOCATE

Crisis intervention in sexual assault requires that the advocate support the victim throughout the rape exam, making sure she is made aware of her options concerning medical and legal issues, and afterward as she gives her statement regarding the incident to the police. In addition, the advocate assumes follow-up contact and advocacy responsibilities during the period following the assault and during the victim's encounters with the criminal justice system.

Usually the police will interview the victim as soon as possible, perhaps even before the exam, since details may fade from memory with time. The victim need not furnish information regarding her personal life or past sexual relationships, except any relationship with the assailant. Police should not ask these questions, and if they do, there is no need to answer them; but because of the nature of their work, police must ask questions pertaining to the most difficult and personal details of the rape. Some of the questions she might expect include:

Do you know the assailant?
What is your relationship to him?
How long have you known him?
Where did you meet him?
Description of the assailant.
Details of scene of the crime.
Details regarding penetration, ejaculation.
Types of sexual acts forced upon the victim

The advocate must not argue with the police, nor should she ask any questions of the victim for the investigator--otherwise, the position of advocacy and caring support is compromised. The advocate should not give opinions as to the victim's credibility if she should be asked. If the questioning by police seems offensive, the advocate should report this to the center.

It is important that the advocate clearly perceive the thin line between

maintaining a cooperative attitude with the police, and protecting and being aware of the victim's rights. It is only through such support that the healing of the-trauma of sexual assault can begin.

During the rape exam the doctor will ask the victim for information regarding the incident. These and other questions are both medically and legally appropriate and necessary for the benefit of the victim:

- Place and time the rape occurred
- Whether there was a weapon involved, or a struggle
- Any injuries resulting from the struggle
- What type of intercourse occurred (vaginal, oral, anal)
- Whether there was any penetration, ejaculation
- What happened after the rape
- Whether the victim showered, bathed, douched since the rape
- Whether there was consensual intercourse before or after the rape
- Questions concerning menstrual history, means of birth control
- Whether victim has ever had intercourse

Notification of Police

The hospital is required by law to report a sexual assault or suspected sexual assault to the police in the jurisdiction where the incident occurred. The victim does not have to make a report to the police or file charges against the assailant. However, reporting the assault may prove helpful to police investigating other incidents, or to the victim should she later decide to file charges.

Follow-up Services

The discussion of follow-up services for medical, counseling, and other related issues is very important for domestic violence and sexual assault survivors. Before a woman leaves the emergency room, information on follow-up issues should be provided. While a survivor should be encouraged to seek follow-up counseling and utilize Women's Center services, the decision to do so must be voluntary. It is helpful to provide some general information about the feelings and reactions women might have after a sexual assault. It is important for the survivor to understand that certain reactions and behavior following a rape are very common and normal due to the circumstances.

When responding to a sexual assault call, the advocate first must introduce herself to the receptionist in the emergency room and arrange to meet with the

victim in a private area away from the waiting room. Often the woman will already be waiting n an examination room. The advocate must knock on the door before entering and introduce herself as a representative from the Women's Center, ask the victim's permission to stay with her throughout the procedure.

The advocate should position herself by the victim's shoulder and out of the way of the medical team. If the doctor or nurse does not explain the procedure to her, the advocate does. The victim should be informed of all options and possible side effects in regard to treatment of sexually transmitted diseases and pregnancy.

Any follow-up contacts should be approached in a very discreet manner. In an effort to avoid confidentiality breeches, an advocate could ask a survivor whether ***or*** not they might be contacted at home.

The Women's Center, Inc. of Columbia/Montour Medical Advocacy Program

The Medical Advocacy program is a co-operative relationship between the local healthcare systems and The Women's Center.

The Women's Center works in conjunction with the Geisinger Medical Center to have a full-time Medical Advocate on site within the hospital. The Women's Center also works with The Bloomsburg Hospital in providing a part time Medical Advocate on site within the hospital. Finally, The Women's Center also has a medical advocacy program for the Berwick Hospital.

The basic purpose of the medical advocacy program is to provide advocacy and accompaniment to victims of domestic violence and sexual assault while they are at the hospital. The other main goal is to provide educational training on domestic violence, sexual assault and related topics to doctors, nurses and all other hospital personnel. The work of the medical advocacy program helps facilitate the following goals:

1. To intervene at an earlier stage of the abuse.
2. Medical documentation could keep the abuser away from the victim by helping support a Protection from Abuse Order.
3. It is important to let the victim know that the health care system recognizes abuse as a health care issue and is equipped to help them receive services.
4. To educate medical staff to have an awareness level of the importance of being able to assess domestic violence accurately and timely.

RELATED PROBLEMS

In this portion of your manual, we will discuss the following program-related topics: drug and alcohol abuse. While every battered woman or sexual assault survivor with whom you deal will not face these problems, they will inevitably arise in some cases. They are problems, which do not necessarily arise as a result of abuse and which may be evident in people who are not physical or sexual abuse survivors. It is important to know, however, that these problems may develop in some people as a form of coping with their abuse.

This section was designed to serve as a resource by providing a limited amount of information on these issues. These problems are complex and go beyond the scope of domestic violence and sexual counseling. It is therefore important to be able to recognize these problems and to determine where to refer individuals to deal with these issues.

DRUG AND ALCOHOL ABUSE

This topic is relevant to the work of domestic violence/sexual assault programs for two basic reasons:

- ✓ A woman's abuser may be an alcohol or drug abuser, therefore, it is important to be aware of the myths and realities surrounding the connection between domestic violence and substance abuse, that was discussed earlier.
- ✓ Some women who participate in our services may abuse alcohol or drugs; therefore, it is important to understand issues related to chemical dependency in women and more specifically, in abused women. These issues include information about specific types of chemical substances and dependencies, "co-dependency" myths and realities, appropriateness of referrals and self-help groups. These issues are discussed in the second part of this section.

--Adapted from material from PCADV Counselor/Advocate Training Manual

Note: The Women's Center does not have to accept a woman into emergency shelter if she is under the influence of drugs and/or alcohol upon arrival.

Facts about Alcohol and Drugs

One of the myths about abuse is that it is caused by alcohol, drugs, unemployment or the pressures of day-to-day living. However, although these are often factors, they can more accurately be viewed as triggers than as causes of

abuse.

Many men experiencing these stresses do not batter, whereas a man who has violently attacked his wife may blame his abuse on stressful incidents, even a trivial or invented one. In regard to drinking, potentially violent men may drink in order to give him an excuse for violent actions, which both spouses may later see as a lapse from norm rather than as a problem.

Furthermore, some men who batter when drinking later stop drinking but continue to batter, switching to some other excuse. Because of the frequency of the presence of drugs or alcohol in an assault or domestic violence situation, we will review some basic facts about substance abuse. This will by no means be a comprehensive study of this issue; rather, we will highlight areas that will help you to respond to hotline callers.

The study of drug and alcohol abuse is ongoing and full of contradiction and conflicting research. Therefore, we will avoid any reference to the causes of substance abuse, or attempt to speculate on possible cures. Instead, we will explain the possible connection between drug/alcohol abuse and victimization. We will focus on two areas: drug/alcohol use by the perpetrator and drug and alcohol use **by** the victim.

Drug and Alcohol Abuse and Victimization

In order to deal with the effects of victimization, people turn to various coping mechanisms in an effort to survive the traumatic results of the abuse. Alcohol and/or drug abuse is one particular coping mechanism that creates serious health problems within the individual in addition to far-reaching social problems.

In studying the dynamics of child sexual abuse, researchers find a high incidence of alcohol/drug abuse by the perpetrators and also, later on, by the survivors. This connection is understandable, if we remember that adults who abuse children were very likely victims of some sort of abuse themselves; therefore, the use of alcohol/drugs may be a means of avoiding the painful emotions surrounding the abuse. Also, with adult incest survivors it is extremely important to remember that drug/alcohol abuse does not cause a person to sexually abuse children or to rape another adult.

One of the myths about domestic violence is that it is caused by alcohol or drug use. Although these are often factors that might have an escalating effect on violent episodes, they do not cause abuse. An abuser may look back on a violent episode and blame it on his use of alcohol or drugs. However, the reality is that a person who is violent and abuses alcohol/drugs will not be cured from perpetrating acts of violence if he stops drinking or using drugs. Also, it is very important to remember that alcohol does not make a nonviolent person violent.

Sexual Assault Correlation with Drug and Alcohol Abuse

A correlation between sexual assault and alcohol exists. Rape is a violent act of aggression and an exercise in expressing power. Drugs ***or*** alcohol may arm the perpetrator with increased feelings of aggression and power. The effects of the drugs/alcohol may allow the rapist to act out more readily. Substance abuse does not cause the perpetrator to sexually assault; however, many of the factors that cause a person to assault another are also evident in the drug/alcohol abuser. For example: a person who feels the need to use drugs and alcohol to gain control over his life may also use sexual control over another as a means to acquire a heightened sense of a powerful self.

Drugs/alcohol are often used as an excuse for sexually abusive behavior. As with domestic violence, the perpetrator (often the husband/boyfriend or someone known to the victim) uses the excuse that he would not have been so forceful if he had not been drunk. However, the perpetrator may choose to act in either a violent or non- violent manner and often uses his drunkenness as a "valid" reason to act violently.

Alcohol shows a consistent connection with patterns of sexual abuse of children. Nonetheless, many social scientists doubt that this large number of sexual offenses means that alcohol causes a perpetrator's sexual interest in children. Drinking may be more of a way in which the activity is excused or rationalized by the offender than a causative factor.

In father/daughter incestuous relationships, alcoholism or overuses of alcohol characterize the father. This alcohol use is probably not only a father's habitual style for coping with anxiety, but also tends to disinhibit his behavior and facilitate sexual abuse. Most studies show that many fathers have been drinking at the time of the first incestuous experience, although they were not alcoholics.

Battered Women and Substance Abuse

Sometimes it is the battered woman who turns to alcohol or drugs to forget about her problem. If you are working with a woman with an alcohol or drug problem, it may take a long time to build her trust to a point where you can make a referral to someone who can help specifically with her alcohol or drug problem. Throughout the process, help her with her specific problems around battering as you would with anyone, and let her know that you care about her as a person. The woman using drugs is usually more out of touch with reality than the alcoholic, but both are extremely sensitive and need lots of reassurance that you care about them

and believe that they are basically OK. One idea to reinforce available support which she can call before she takes a drink or uses drugs. Confine your practical discussion of the battering situation to the times when she is not under the influence of alcohol or drugs.

If an alcoholic woman calls you while she is drunk, it is important to determine whether or not she is in danger. Often a woman who is drunk will tell you about a battering incident as though it is happening right now, when in fact it happened earlier but she is only now in touch with her feelings due to the alcohol.

Most victims will not call in the midst of fighting because they are too wrapped up in the fight. Occasionally they will call while still fighting and in danger. If you think there is a chance that a woman is in danger, you should take the responsibility of sending the police because she may be too drunk to make this decision. In this case it is important to advocate for her with the police. They will be inclined to view her as "just another drunk," especially if it turns out to be a false alarm. You can explain to them that there was a chance that she was in real danger and that you expect and appreciate their protection of her now and in future incidents-let them know there is a real threat of danger behind this incident. Also, sending the police lets her know that you take her situation seriously and are ready to offer real help.

If the caller is not in danger but is drunk and wants to talk about her situation, realize that she may talk on and on without making real progress in sorting things out. Don't waste time and energy discussing the details of the situation at this time, but don't hang up. Instead, let her know that you know she is drunk, and communicate your caring, support and willingness to help. Validate her as a person, remind her or help her think of times she has felt good, and emphasize your desire to help her. Let her know that you understand what is happening to her but that neither of you can deal with it effectively while she is still drinking.

The caller who frequently uses alcohol may call the hotline over and over again. You may find that she does not want to talk to you when she is sober-she may be ashamed or she may deny the problem except when she is drinking. You may want to keep calling back occasionally to let her know that you are there whenever she wants to talk, and encourage her to call you before she takes a drink, when she is upset and feels like drinking. This is also a good time to meet her to help her work toward solutions and support her in remaining sober.

If you feel that the victim's life is in danger, talk to her about going to the hospital. Talk about finding someone close, a friend or a relative, to go with her. If the user refuses to go to the hospital, give whatever information you can to help her cope with the situation, stressing the importance of getting medical attention. If the caller has been a victim of abuse in this situation and does go to the hospital, an advocate may meet her at the hospital and follow through as normal.

We have given you a brief overview of the correlation between substance abuse and the incidence of assault/abuse. What is more important for you to remember as you work as crisis intervention counselors is not to judge a hotline caller because of her use of drugs and/or alcohol. Use the guidelines outlined in this chapter to help you respond emphatically to hotline callers who have been affected by substance use or abuse.
--From: ***Counseling Me Abuse l/victim,*** by Linda Shaw for PCADV and Women's Services, Westmoreland County

Why Women Develop Drinking Problems

There is no single cause of alcoholism for either women or men. One's psychological makeup, environment and physical factors probably all interact to contribute to the development of an alcohol problem. Professionals in the field agree, however, that most of the alcoholic people they work with suffer an unusual amount of stress and deprivation in their lives.

As a group, women suffer a great deal of stress-and some of the stresses are very different from those faced by men. Since the traditional role society has defined for women and men produce quite different behavior, goals, self-images and life experiences, women face certain problems in common that are not relevant to men.

From childhood, women have been taught that as the "second sex," they are expected to derive their sense of self worth primarily through relationships with men, rather than through achievements and activities of their own. Until recently, women were rarely encouraged to develop as independent persons with strong, secure identities. That is not to say that women's drinking problems stem entirely from their role in society. But regardless of what women do with their lives, they cannot escape society's judgment that, on some very basic level, they are inadequate because they are women. Studies repeatedly show that women drink primarily to relieve loneliness, inferiority feelings and conflicts about their sex role, regardless of their lifestyle.
--From Centre County Women's Resource Center
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DRUG USED	PHYSICAL SYMPTOMS	LOOK FOR….	DANGERS
ALCOHOL (beer, wine, liquor)	Slower reaction time, drowsiness, slurred speech, personality changes, can lead to alcohol addiction	Hidden bottles, slack facial expression, deliberate movements, lack of coordination, memory loss	High risk for accidents, high risk to injure others, medical problems: ulcers, blood pressure problems, destruction of the liver, death from overdose
AMPHETAMINES, CRYSTAL METH, CRANK (street names: bennies, black beauties, crystal, dexies, pep pills, speed, uppers, ups & white crosses)	Bizarre behavior, violent behavior, feeling of euphoria, rapid speech, giggling, silliness, increased heart & respiration rates, increased blood pressure, dilated pupils, decreased appetite, anxiety, blurred vision, sleeplessness, dizziness, dry mouth & psychological addiction	Tablets or capsules in variety of shapes & colors; white (or colored) crystalline powder in small plastic bags or vials; can be liquid form; can be prescribed by physician for legitimate use treating narcolepsy & ADHD	Delusions, hallucinations, feeling of paranoia, extreme weight lose & malnutrition, ulcers, brain damage, irregular heart beat, physical collapse, death from overdose; frequent use can lead to: mental illness, suicide & violent death
BARBITURATES, BENZO-DIAZEPINES (street names: barbs, downs, downers, goof balls, ludes, reds, sopors, T's, 714s)	Similar to the effects of alcohol; slurred speech, staggering gait, poor judgment, slow/uncertain reflexes, lack of coordination, temporary memory loss, physical & psychological addiction	Pills of varying color, size & shape; can be in liquid form or suppositories, can be prescribed by physician for legitimate use treating anxiety, stress, tension, panic attacks, sleep disorders	Drowsiness, convulsions, coma, death from overdose, suicides, should not be mixed with alcohol
COCAINE, CRACK (street names: big C, blow, coke, flake, lady, nose candy, rock, snow, snowbirds, white	Short period of energy/rush, followed by depressed/down feeling; disturbances in heart rhythm, increased heart/respiratory rates, elevated blood pressure, dilated pupils, decreased appetite, excessive activity, talkativeness, irritability, nervousness, agitation; highly additive, both psychologically & physically	Cocaine: White crystalline powder in small plastic bag or tin foil; small screens or mirrors, candles, razor blades Crack: small rock-like pieces, sometimes in glass vials or plastic packages; pipe	Long term use leads to: loss of concentration, memory, energy & interest in sex; anxiety, paranoia, delusions, heart attack, high blood pressure, depression, continual sinus problems, sudden death from heart attack or stroke, death from overdose, suicide

DRUG USED	PHYSICAL SYMPTOMS	LOOK FOR….	DANGERS
HALLUCIN-OGENS: DMT, LSD, MDMA (ecstasy), PCP, MUSHROOMS (street names: angel dust, caps, killer weed, magic mushrooms, shrooms, trips)	Unpredictable effects: severe hallucinations; changes in perception, thought & mood; distorted concept of time, self & sensation; increased heart rate & blood pressure; dilated pupils, sweating, loss of appetite, tremors, dry mouth, sleeplessness, flashbacks; psychologically addictive	Can be in tablets, discolored sugar cubes, tube of liquid, can be concealed in candy, squares of paper w/ design, any color powder	Unpredictable, bizarre or aggressive behavior, convulsions, coma, heart & lung failure, aneurysm, chronic exposure causes brain damage, prone to accidental death (i.e., drowning, fire, automobile accidents)
INHALANTS: AEROSOLS, ANESTHETICS, CHEMICALS & SOLVENTS (consumer products being misused: gasoline, glue, hair spray, lighter & cleaning fluids, nail polish remover, paints)	Slow down the body's functioning, nausea, sneezing, coughing, nose bleeds, lethargic, drunk appearance, blank expression	Any of these products, along with paper bags, handkerchiefs, rags or other paraphernalia	Overall, lung, brain, liver or kidney damage occurs, anemia, weight loss, tolerance develops with repeated use; deep breathing of vapors can cause: loss of self-control, violent behavior, unconsciousness, death; sniffing highly concentrated amts. of solvents can cause heart failure & instant death; inhalants can cause suffocation & death
MARIJUANA (street names: boo, grass, pot, smoke, weed)	Rapid pulse, bloodshot eyes, dry mouth & throat, sleepiness, wandering mind, enlarged pupils, lack of coordination & concentration, craving for sweets, increased appetite, mild hallucinations; psychological addiction	Red puffiness under eyes, strong odor of burnt leaves, cigarette paper, discolored fingers	Inducement to take stronger drugs, paranoia, persistent anxiety, memory difficulties, decreased interest & motivation in daily activities (school & work); cancer, emphysema, heart damage
OPIATES: CODEINE, HERION, MORPHINE, OPIUM (street names: brown sugar, dope, horse, junk, skunk, smack)	Restlessness, nausea, vomiting, drowsiness, needle marks, watery eyes, runny nose, highly addictive; Cough medicine containing codeine or opium can also be abused	Powder, dark brown chunks, needle or hypodermic syringe, cotton tourniquet, burnt bottle caps or spoons; empty bottles of cough medicine	Death from overdose, HIV/AIDS from infected needles, mental deterioration, destruction of brain & liver, highly addictive

DRUG AND ALCOHOL MANAGEMENT

Guidelines for Dealing with Someone under the Influence of Drugs and/or Alcohol

- Proceed with caution.
- Maximize predictability; tell the person exactly what you are going to do next (I am going to walk back to the desk and sit down).
- Move and speak slowly and calmly. This helps to reduce panic.
- Never give food or beverages as a general rule.
- Don't block exits; always allow the person and yourself an escape route.
- Physical restraint should not be used unless it is absolutely a last resort in preventing the person from hurting herself and/or others.
- Try to discover what the person took, taken, and amount taken.
- This information can save valuable time for medical personnel.
- If possible, have the person seated in a quiet area, with little stimulation.
- DO not leave the person alone.
- Do not induce vomiting; use home remedies, or antidotes.
- If the situation appears life threatening --- respiratory collapse, convulsions, delirium, tremors –Call 911 Emergency Services
- If the person is intoxicated, but not life endangered or suicidal, don't spend too much time with her.
- This is not the time to point out the woman’s irresponsible behavior, or to try to rationalize. Save it for the morning.
- If you are unsure of the drug in use, do the opposite of the clients behavior, i.e. if hallucinating, you define reality; if stimulated, help to bring them down.
- Isolate the person in crisis. Ask for assistance from staff or other residents.

Co-Dependency and "Women who love too much": Helpful to Battered Women?

While the term, 'co-dependency," has been commonly used over the last few years, it is interesting to note people's reactions when asked to describe what 'co-dependency" actually means. For those of us who, by virtue of our professions (therapists, counselors, social workers, substance abuse staff), are "supposed" to know what the term means, we either rattle off the definition that we learned at our latest workshop or make something up that sounds smart. For others who have

read any of a number of best-selling books on the subject, (Robin Norwood's, ***Women Who Love Too Much,*** being the most popular), any definition would reflect the view of whatever author had just been on ***Oprah or Mantel.*** In any case, however, a number of observations are apparent. First, no one seems very sure what co-dependency actually refers to, and second, most of us feel a little bit embarrassed at the fact that whatever it means, we are probably walking examples of it.

The proliferation of books such as Norwood's and others with equally ubiquitous titles as ***How to Love a Difficult Man; Women Men Love; Women Men Leave; Smart Women/Foolish Choices;*** and ***How to Break Your Addiction to a Person*** is, I would suggest, a dangerous phenomenon. Perhaps "dangerous" is too provocative a description. However, this article will suggest a number of reasons, why we, in the battered women's movement in particular, need to be especially attentive to and critical of the themes of these books.

Historically, the "co-dependency" label was preceded by the term, "enable," in the alcoholism and drug abuse field. In the early 40's**,** most alcoholics were identified as men due to the social mobility that afforded males the opportunity to drink and sometimes abuse alcohol in public settings such as bars, taverns, clubs, parties and even into the streets. When alcoholism treatment models began to gain prominence, it became evident that if men were most often the "identified patient," then those who supported them in their addictive systems would have to be guessing who? They were wives, mothers, daughters, secretaries and all the other females in men's lives that should have been taking better care of them rather than "care taking" them. While the term, "enabler," was probably not intended to be sexist, the cultural context of its development and usage naturally implicated women.

With the influence of the women's movement over the last 30 years, the focus of women's health resulted in our growing awareness of the millions of women who were quietly abusing drugs and alcohol in the privacy of their own homes. With the acknowledgment that both men and women could have drug abuse problems combined with women confronting the traditional notion that they were being blamed for "enabling" their men's problems and perhaps due to the health industry just needing another disease to treat (and charge health premiums for), the alcoholism model was expanded to include all drug (and more recently and regionally, chemical) "dependency" whose "enabler" counterpart is often referred to as the "co-dependent." In addition, co-dependency is now almost a diagnosis in and of itself, and one can receive services for a co-dependency

problem separate from any drug-related situation.

With this historical background as a context, then, we need to re-ask why it is that so many of us feel uncomfortable with the notion of co-dependency. And, if we look closer, it is probably not all of us that are uncomfortable but mainly us women. I would suggest that women chafe at the concept of co-dependency because we feel that the term naturally implicates us and not men. And what does all of this have to do with battered women in particular?

Co-dependency, as manifested, unfortunately, in books like ***Women Who Love Too Much,*** is basically a woman-blaming model. Yes, men can be co-dependent, too. Yes, there really are women who love too much. Yes, co-dependency is helpful to women. But, co-dependency, as a concept that is used with, for and by women, is still inherently sexist. And more importantly, it can be very dangerous for battered women.

First, co-dependency (relationship addiction, loving too much- call it whatever you want) is very clearly applied disproportionately to women. At any bookstore most of the titles speak about female love addictions, women loving too much, women making foolish choices and how women can get good men. These books are not intended to assist men in changing their behavior; on the contrary, they compel women to take responsibility for their unhappy situations and reinforce in men that women are the source of not only women's problems but men's problems as well. For battered women co-dependency, at best, says learn not to love those abusive men so much; at worst it implies that whatever abuse you get is due to your inability to break your addiction and dependency on your batterer. What about batterers learning not to control women so much? What about the abuser breaking his dependency on violence as a means of attaining power over others?

Co-dependency also implies that if women change, they will not only be happy, but they will affect change in their partners. For battered women, that equation maintains society's long held belief that we can stop the abuser from violence if we just find the "right" thing to say, do, cook or wear. Not only that, but if a battered woman got help with her "dependency relationship problem" it would undoubtedly convince the batterer that he should stop beating her. As most workers in the battered women movement know, such a scenario rarely, or perhaps never, occurs.

Co-dependency is a concept that focuses almost exclusively on the intrapsychic, aspect of an individual. In other words, it is not sexism, racism or other forms of oppression in society, or the constraints of a penalizing welfare system, or unequal access to childcare, or any of a myriad of other cultural factors that contribute to "bad relationships." It is clearly a co-dependent personality, dysfunctional parents or something having to do with one's psyche that causes one to “love to much.” The emphasis on the individual, to the exclusion of society’s sanction of male violence, is not only a limited but also an inappropriate analysis of battering in intimate relationships.

So why do so many women - battered women and battered women's movement proponents - embrace these concepts, these books and these theorists? There are two possible reasons. First, many of us can identify with the case histories in these books because parts (or perhaps all) of the stories speak about our lives and/or the lives of many women we know. Therefore, if the women in those books are helped by Robin Norwood and the co-dependency model, maybe we can, too. Related to that is the deeply entrenched notion that we, as women, are not as worthwhile as men in our culture. Ultimately that self-hatred is translated into our assuming responsibility for our problems (and everyone else's), and therefore, seeking whatever solutions will solve those problems. The true danger in such a situation, however, is that we are once again seduced by a subtle form of sexism that falsely empowers us to believe that we can change ourselves as well as those that seek to contort us In the case of battering, women have literally been beaten into submission by abusers who seek to control them read Women Who Love Too Much, go to dependency groups and start believing that if they change their behavior, the battering will cease. Instead of king controlled by the abuser, a battered woman begins to be controlled by a "concept." That concept, never directly, but inherently, blames women for the abuse.

A final but very important consideration regarding co-dependency: most of the literature on co-dependency is from a decidedly white, middle class, heterosexual perspective. If one is not a member of any of those classes, it is probably reassuring to know that co-dependency doesn't apply to you. However, it is more likely ignorance combined with racism, homophobia and classism that resulted in such a limited perspective. Such an oversight further substantiates the fact that the model does not take into account a social-political perspective: one of the hallmarks of the battered women's movement. Related to the above, an examination of the coping strategies that many oppressed groups evidence which have been interpreted as co-dependent (such as passivity, putting others' needs first, etc.) is another necessary, but often overlooked, task in any analysis of this

"syndrome."

Throughout this article references have been made to the battered women with the batterer as male. A more in-depth analysis of the special issues that lesbians and gay men who are battered face was not within the scope of this article. However, the same limitations of the model apply to lesbians and gay men who are battered with the additional overlay of survivors of battering encounter with the co-dependency concept.

It is incumbent upon those who are working to eliminate negative images of women to understand and critique any theory that has the kind of widespread popular support that "co-dependency" has. While the co-dependency model can be helpful when placed more firmly within a socio-political context, the battered women's movement has a responsibility to be vigilant about the use of this model not only with battered women, their children and abusers, but also among service providers. As we consider using the term, co-dependency with battered women or any women who we think may 'love too much," perhaps we first need to ask ourselves, as one powerful woman does: "What's love got to do with it?"
---Valli Kanuha, NCADV Conference